MEDICAL EXAMINER'S CERTIFICATE
B-328 NEW 8-2001

STATE OF CONNECTICUT - **DMV**
On The Web At http://dmvct.org

I CERTIFY THAT I HAVE EXAMINED *(Print Name of Individual Below)*

In accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when:

- ☐ Wearing Corrective Lenses
- ☐ Wearing Hearing Aid
- ☐ Qualified by operation of 49 CFR 391.64
- ☐ Driving within an exempt intracity zone (49 CFR 391.62)
- ☐ Accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ Accompanied by a _____ waiver/exemption

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER	**TELEPHONE NUMBER**	**DATE**
X		
NAME OF MEDICAL EXAMINER *(Please Print)*	☐ MD ☐ DO ☐ Physician Assistant ☐ Advanced Practice Nurse ☐ Chiropractor	
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO.	**ISSUING STATE**	**MEDICAL CERTIFICATE EXPIRATION DATE**

SIGNATURE OF DRIVER	**DRIVER'S LICENSE NUMBER**	**STATE**
X		
ADDRESS OF DRIVER		